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Issue date: 19Nov2001

In the Matter of	:	
EDGAR JUSTICE	:	**Case No. 1996-BLA-0940**
Claimant	:	
v.	:	
ITMANN COAL COMPANY	:	
Employer	:	
and	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS	:	
Party in Interest	:	

DECISION AND ORDER ON REMAND

This matter is before me pursuant to a remand by the Benefits Review Board of a Decision and Order awarding benefits issued February 9, 1999. In its decision, the Board, relying upon an advocates description of an Administrative Law Judge's findings of facts, reversed the caricature and vacated the award. A discussion of the findings and the issues on remand are set forth below. To ease the burden of review, several of the actual findings entered in this matter are highlighted. The opinions of four physicians remain at the center of the controversy.

Dr. Rasmussen

As noted in previous decisions, Dr. Rasmussen opined that Claimant is totally disabled due to coal dust exposure and cigarette smoking, and the Employer challenged his conclusion. The Employer argued that the "Judge never

provided any reason for stating that Dr. Rasmussen's opinion is well-reasoned and documented," and the Board found that the "judge failed to provide a basis for his finding that Dr. Rasmussen's opinion was 'well-reasoned and documented."[1] Yet, **the decision found wanting of a "basis" carefully considered the strengths and weaknesses in Dr. Rasmussen's analysis and weighed them accordingly.** The Board may not, contrary to its own decisions cited below, find merit in the "basis," but the judge did "not fail to provide a basis," and what was provided should be considered on the merits.

As discussed in the prior decisions in this matter, Dr. Rasmussen **examined Claimant on October 2, 1995. He obtained medical and work histories, and a report of Claimant's symptoms. During the physical examination, he detected reduced breath sounds, but no rales, wheezes, or rhonci. He administered pulmonary function and blood gas tests, and reviewed a report by Dr. Patel which interpreted an x-ray as positive for pneumoconiosis.** Dr. Rasmussen diagnosed pneumoconiosis (by **exposure history** and **x-ray**) and emphysema (by airflow obstruction and SBDLCO). He concluded that Claimant is disabled from his coal mine work due to both cigarette smoking and coal dust exposure, and described the latter etiology as a "significant contributing factor." While the Board in this matter could find "no basis" supporting Dr. Rasmussen's opinion, other Board decisions in Hoffman v. B&G Construction Co., 8 BLR 1-65 (1985); Hess v. Clinchfield Coal Co., 7 BLR 1-295 (1984); and Justus v. Director, 6 BLR 1-1127 (1984), clearly provide that the factors highlighted above, and cited in the prior decisions entered in this matter, are more than sufficient documentation to support Dr. Rasmussen's opinion.

Dr. Rasmussen noted that Claimant's **blood gases** and his **pulmonary function test** revealed "severe, partially reversible, obstructive ventilatory impairment. Maximum breathing capacity was markedly reduced. The single breath **carbon monoxide diffusion capacity** was moderately reduced. The **DL/JA** was minimally reduced." (Rasmussen Report p. 2).

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[1]Reversing straw findings set up by employer's counsel does not advance consideration of this matter. The regulations require and Claimant is entitled to a review of the judge's findings not a stylized version of those findings prepared by the lawyer for a disappointed litigant.

Moreover, as I noted in my March 25, 1997, decision and February 2, 1999 decision, and here again, in weighing Dr. Rasmussen's opinion, the decisions issued in this matter have taken into consideration the fact that **Dr. Rasmussen relied partially, not as the Employer misrepresents "heavily," upon an erroneous positive x-ray reading by Dr. Patel.** The weight I have accorded Dr. Rasmussen's opinion is, however, diminished accordingly.

In addition to the x-rays, however, **Dr. Rasmussen also relied upon Claimant's exposure history to both coal dust and cigarette smoke.[2] He evaluated Claimant's pulmonary function tests, and, he noted partial reversibility.** Further, as I noted in my March 20, 1997 decision , and the Board did not disturb it on appeal, **Dr. Rasmussen also considered "markedly reduced" single breath carbon monoxide diffusion capacity.** The physicians in this proceeding all agree that coal dust exposure can cause a permanent obstructive defect and **Dr. Rasmussen, based upon the above medical considerations, attributes the fixed component of Claimant's impairment to both coal dust exposure and cigarette smoking.**

The Employer inquired of the Board as to "exactly, what remaining in Dr. Rasmussen's opinion, qualifies it as reasoned, or documented, or credible." Yet, **Dr. Rasmussen considered the miner's physical examination results, symptoms, pulmonary function and blood gas data, smoking and coal mine employment history, and both a fixed and reversible component of a demonstrable respiratory impairment.**

While the Employer detects "no reasons" for crediting Dr. Rasmussen's opinion, all of the foregoing factors were cited in the prior decisions. **The Board has, on numerous other occasions, held such clinical elements when considered by a physician are sufficient to support a reasoned medical**

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[2]Findings and conclusions rendered in the decisions and orders issued in this matter on March 27, 1997, and February 2, 1999, and not disturbed on appeal are hereby adopted and incorporated herein by reference. These findings weigh and consider the x-ray evidence under Section 718. 202(a)(1) in conjunction with the medical opinion evidence under Section 718.202(a)(4), in compliance with Island Creek Coal Co. v Compton, 211 F.3d 2203 (4th Cir. 2000). The record contains no biopsy or autopsy evidence or indications of complicated pneumoconiosis.

opinion, Hoffman v. B&G Construction Co., 8 BLR 1-65 (1985); Hess v. Clinchfield Coal Co., 7 BLR 1-295 (1984); and Justus v. Director, 6 BLR 1-1127 (1984), **notwithstanding the fact that the physician partially, but mistakenly, relied upon a positive x-ray reading. Church v. Eastern Associated Coal Corp., 20 BLR 1-8 (1996).** Crediting Dr. Rasmussen's opinion under these circumstances is not inconsistent with Board Law, and the vociferousness of the employer's argument to the contrary would not seem to warrant a departure from fairly well-settled Board doctrine.

Should the Board, after consideration of the foregoing discussion, again find that reasons for crediting Dr. Rasmussen's opinion are "non-existent" or insufficient, further remands would seem be unnecessary since I have no other reasons for according credit to Dr. Rasmussen's opinion.

Dr. Zaldivar

The Employer next advised the Board that "the judge substituted his opinion for that of the expert [Dr. Zaldivar] when he presumed that because smoking can paralyze cilia, smokers are ...presumed to be impaired," and the Board dutifully found that the "...judge improperly substituted his opinion for that of Dr. Zaldivar."[3] These subjective mis-characterizations represent a complete misunderstanding of the findings entered in this matter.

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[3] An observation regarding this "substitution" argument seems warranted. The Employer demands that the trier of fact provide an in-depth analysis of the medical report relied upon by claimant even as she vigorously objects to an analysis of the medical opinions relied upon by the employer. In the latter case, she accuses the trier of fact of substituting his opinion for that of her physicians because the analysis reveals flaws in their opinions. She can thus euchre a trier of fact in either case; demanding analysis of medical reports she opposes, while invoking the "substitution" ploy to deflect consideration of the merits of an analysis critical of report she sponsors.

Of course, we do not and have not interpreted clinical data, but triers of fact have always been permitted to analyze and question the rationale, reasons, or explanations provided by a physician. Yet, if the latter is no longer permissible, it will vastly simplify black lung claims adjudication in the future. Analyzing a medical opinion is considerably more time consuming than simply checking off the data points considered by a physician in the process of preparing his or her report.

The administrative law judge did not "assume," as the employer urged with the Board's concurrence, that "claimant's coal dust exposure must have had a negative effect on claimant's lungs which were already compromised by claimant's smoking history." BRB at 5. **The decision contained no such assumptions**. To the contrary, the decisions have discussed important unanswered questions in Dr. Zaldivar's analysis; gaps in the evidence which employer insists can not be considered. The March 25, 1997, decision, for example, noted:

> Dr. Zaldivar opined that there is no synergy between cigarette smoking and coal dust exposure, **however, he also stated that cigarette smoking paralyzed the cilia in smokers, and that these cilia help remove coal dust in non-smokers.** Left unexplained in Dr. Zaldivar's report is the effect of coal dust in the lung of miners whose cilia are paralyzed by smoking. I do not second guess Dr. Zaldivar or attempt to "play doctor" by observing that as a trier of fact, his report is unpersuasive in these respects.

The February 2, 1999, decision observed that the:

> employer's counsel insists that the trier of fact, initially, and the Board, subsequently must blindly accept whatever theory or conclusion their experts may proffer. As the Employer's brief to the Board demonstrates, an attempt to evaluate or question the internal consistency of an employer-sponsored medical report is subject to the accusation that the trier of fact is second guessing the employer's expert or worse "playing doctor." This litigation tactic is often invoked by a few practitioners to divert attention from the flaws in their evidence.

The effect of coal dust and smoking on lung cilia was specifically raised by Employer's counsel in the questions she directed to Dr. Zaldivar at his deposition. Yet according to Employer's counsel, a trier of fact is forbidden from raising important questions generated by the evidence she developed. Apparently, we must accept it exactly as she delivers it to us.

I fully understand that Dr. Zaldivar opined that there is no synergy between smoking and coal dust inhalation. Yet, the Employer's emotional protestations to the contrary notwithstanding, **it has never been found, presumed, or assumed that there is any such synergy in any decision which has issued in this matter. What has been questioned is the basis and rationale Dr. Zaldivar employed in reaching his conclusion in light of his own explanations of the paralyzing effect of smoking on lung cilia.** That would, until now, seem to be an appropriate function of a trier of fact. *See,* **Mabe v. Bishop Coal Co.**, 9 BLR 1-67 (1986)(A report which is internally inconsistent and inadequately reasoned may be entitled to little probative value).

Thus, Dr. Zaldivar testified that (1) smoking paralyzes lung cilia, and (2) in non-smokers lung cilia are the normal mechanism for removing coal dust. (Zaldivar depo. at 16). Given these two predicates, if the cilia in the lungs of non-smokers act to remove inhaled coal dust as Dr. Zaldivar testified, and if the cilia of a smoker are paralyzed and can not perform the function of removing inhaled substances such as coal dust as Dr. Zaldivar testified, some further medical explanation for the conclusion that synergy does not exist in this situation is warranted. Dr. Zaldivar provided the conclusion that there is no synergy, but he provided no explanation in support of his conclusion, and the **employer cites to no explanation. It merely insists that Dr. Zaldivar's opinion be fully credited in any event, and to do otherwise substitutes the opinion of those who raise the question for the doctor's opinion.**

Unless a trier of fact is compelled uncritically to accept every physician's opinion at face value, I here find, as I found in my prior decisions in this matter, absent a medical explanation supporting Dr. Zaldivar's conclusion that there is no synergy in these circumstances, I am not prepared to fully credit his opinion. This is not to say, as the employer argued in her brief, that the judge "assumes" there is synergy between smoking and coal dust. To the contrary, the prior decision made no finding in respect to whether synergy does or does not exist, **and I make no such finding here. The issue is Dr. Zaldivar's own testimony which cast doubt upon his affirmetaive conclusions and raised legitimate questions which he did not address.** Consistent with **Cosaltar v. Mathies Coal Co., 6**

BLR 1-1182 (1984), Dr. Zaldivar's report is rejected because I can not determine the basis for his affirmative assertions, which I find are not well-reasoned, that synergy does not exist in this instance; and notably on two appeals neither the employer nor Board has addressed the merits of this issue by providing an explanation or citing evidence which would clarify this question. **I do not credit Dr. Zaldivar's report because, as trier of fact, I am unable to ascertain any explanation or rationale in Dr. Zaldivar's report or deposition which supports an important conclusion he affirmatively advocated upon questioning by the employer's lawyer.** Clark v. Karst-Robbins Coal Co., 12 BLR 1-149 (1989) (en banc)

Should the Board find that a judge may not probe the unanswered questions in a medical evaluation, or should it find that Dr. Zaldivar, a specialist in pulmonary diseases, has answered these questions to the Board's satisfaction, then Dr. Zaldivar's conclusion should be fully credited in this proceeding by the Board without the need for further remand since I have no other reason for not according it .

Dr. Jarboe

In his analysis of claimant's condition, Dr. Jarboe, a specialist in pulmonary diseases, concluded that **the non-reversible component of claimant's impairment is not caused by pneumoconiosis because, "in the absence of cigarette smoking,** it (pneumoconiosis) rarely causes obstruction of this severity." The February 9 decision found this analysis unpersuasive and illogical, noting that the severity of Claimant's impairment occurs, not "in the absence of cigarette smoking," but in the presence of both cigarette smoking and coal dust exposure. Yet, the Board quoting a portion of the February 2, 1999 decision, concluded that "Dr. Jarboe was aware of claimant's smoking and coal mine employment histories," and therefore, "Dr. Jarboe did not postulate facts which were not in evidence." **It is respectfully submitted that what Dr. Jarboe knew about the facts in evidence is not synonymous with what Dr. Jarboe postulated.**

Dr. Jarboe's willingness to discount the presence of pneumoconiosis because claimant's impairment was too severe "in the absence of cigarette smoking" postulates circumstances which are not present in this record. **Whether or not pneumoconiosis in a non-smoker would cause an obstructive**

impairment as severe as Claimant's impairment is not the issue. This claimant is a smoker. In this instance, the severity of his impairment occurs in the presence of both cigarette smoking and coal dust exposure, and Dr. Jarboe does not explain how the degree of impairment would be non-diagnostic of pneumoconiosis under these circumstances. The Board's decision in **Knizer v. Bethlehem Mines Corp., 6 BLR 1-5 (1985), permits the trier of fact to reject a medical opinion in such circumstances**. As found in the prior decisions in this matter, I here again find that Dr. Jarboe postulates facts which do not apply to this claimant as revealed by the evidence in this record, and I reject his opinion. Knizer v. Bethlehem Mines Corp., 6 BLR 1-5 (1985),

Should the Board find, however, that it is satisfied with Dr. Jarboe's conclusion that "pneumoconiosis is not present because claimant's impairment is too severe in the absence of cigarette smoking," or indeed should the Board find that no further explanation by Dr. Jarboe is needed, a remand would seem unnecessary for further consideration of this issue since I have no other reasons for rejecting Dr. Jarboe's report.

Dr. Fino

The employer argued that in analyzing Dr. Fino's discussion of the pulmonary function data the "Judge mischaracterized Dr. Fino's opinion and substituted his own opinion for that of the expert." The Board concurred holding that "the interpretation of the objective data is a medical determination for which an administrative law judge cannot substitute his own opinion." BRB at 8. Here again the employer's characterization of the finding, not the actual findings, were the subject of the discussion on review.

Contrary to fact, **the analysis in the February 2, 1999 decision did not interpret the "objective data." It analyzed the internal inconsistencies and lack of explanations for conclusions rendered by Dr. Fino, a specialist in pulmonary diseases.** While the employer would have the Board eschew any consideration of the merits, it would seem inappropriate to decline to evaluate the merits before uncritically dismissing Mr. Justice's claim. Yet, a careful review of Dr. Fino's report discloses several inconsistencies and gaps in his analysis which diminish the weight of his opinion.

Dr. Fino states that Claimant's defect is purely obstructive, but the "presence of obstruction does not rule out pneumoconiosis." **Dr. Fino reasons that cigarette smoking rather than coal dust is causing the obstruction because the obstruction shows proportionally more involvement in the small airways, than the large airways.** Dr. Fino explained that FEV1 and FEV1/FVC ratio measure flow in the large airways while FEF 25-75 measure flow in the small airways.

Dr. Fino concedes that Claimant's test show an obstruction in both his large and small airways, and that pneumoconiosis can cause an obstructive defect. Yet, **Dr. Fino does not explain how the involvement of both the large and small airways in Claimant's case, is inconsistent with the presence of pneumoconiosis in the lungs of a cigarette smoker.** Dr. Fino tells us that the large airway flow is measured by the FEV1 and the FEV1/FVC ratio. Dr. Zaldivar's pulmonary function tests yielded FEV1 and FEV1/FVC ratio values which qualify under the regulations at 20 CFR §718.204(a)(1) as indicative of total disability, and Dr. Rasmussen interpreted the pulmonary function data as indicative of total disability.

Considering the regulations, the test results, and the contrary medical opinion evidence, Claimant's large airway flow alone, as measured by the FEV1 and FEV1/FVC ratio, **which Dr. Fino advised should be used**, **is sufficiently reduced not only to satisfy the disability criteria set forth in the regulations, but support Dr. Rasmussen's medical opinion which contradicts Dr. Fino.**

Dr. Fino next observes that the small airways flow is more reduced than the large airways flow, and this is not consistent with a coal dust related condition, but is consistent with smoking, emphysema, asthma, and non-occupational bronchitis. Dr. Fino's discussion is somewhat vague. It is unclear whether he is describing the anticipated effects of coal dust exposure, alone, cigarette smoking, alone, or a combination of both, and neither the employer nor the Board has clarified this issue. Yet, using the data Dr. Fino tells us to use, the FEV1 and FEV1/FVC ratio to measure flow in the large airway, the record shows a disabling obstruction in the large airways as measured by the table values set forth in the regulations, Fields v. Island Creek Coal Co., 10 BLR 1-19 (1987), and the contrary medical opinion evidence in this record. Compton, *supra.* In the past, the Board itself has insisted

that such contrary probative evidence be considered.

Moreover, since the **large airway is the area of the lungs in which Dr. Fino tells us he would expect pneumoconiosis to manifest itself**, it is unclear why the additional involvement of the small airways caused by cigarette smoking would be inconsistent with coal workers' pneumoconiosis in the large airways. *See,* Clark, *supra*. This is, of course, an important consideration in light of the Fourth Circuits holding that pneumoconiosis need only be a contributing cause, not the sole cause of a disabling impairment.

As trier of fact, **I conclude that Dr. Fino's conclusion that Claimant "does not suffer from an occupationally acquired pulmonary condition," is not persuasively supported by his discussion of the pattern of large and small airway involvement.** Mabe v. Bishop Coal, *supra*.

Dr. Fino, like Dr. Jarboe, next comments that "reversibility following bronchodilators implies that the cause of the obstruction is not fixed and permanent." Because pneumoconiosis is not reversible, Dr. Fino states that "improvement following bronchodilators showing reversibility to the overall pulmonary impairment is clearly evidence of a non-occupationally required pulmonary condition..." I deem it essential to exercise caution in reviewing Dr. Fino's sweeping generalizations. Knizer v. Bethlehem Mines, *supra*.

It is true the record shows some improvement in Claimant's pulmonary function with bronchodilators. However, it also shows that Claimant's post-bronchodilator results were still low enough to satisfy the regulatory criteria for establishing total disability. The October 2, 1995 pulmonary function test showed an FEV1 of 1.45 and an FEV1/FVC ration of 45%. Post bronchodilator Claimant's FEV1 was 1.62 and his FEV1/FVC ratio was 44%. Claimant at the time of the test was 70 years old and was 69 3/4" tall. The record thus shows that both his pre and post bronchodilator pulmonary function studies satisfied the disability criteria set forth in the regulation. Dr. Fino is, of course, free to characterize the fact that Claimant's condition as partially reversible as evidence that his condition is not fixed and permanent, **however, he provides no rationale whatsoever to explain why Claimant's obstruction is still present in a degree sufficient to meet regulatory disability criteria after bronchodilators are administered.**

Thus, if bronchodilators improve reversible conditions as Dr. Fino contends, it may be inferred that portions of obstructive conditions which are not improved by bronchodilators like pneumoconiosis are not reversible. Under such circumstances, Dr. Fino's contention that any evidence of reversibility is "clearly evidence" of the absence of pneumoconiosis **provides an inadequate analysis of the irreversible component of Claimant's condition.**

While the reversible component in Claimant's overall impairment may be non-occupationally acquired; Dr. Zaldivar noted that, after bronchodilators, he found evidence that "there is an irreversible obstruction," which Dr. Fino seems unable to detect or acknowledge. **Dr. Fino thus has failed to provide a documented well reasoned explanation to support the contention that the component of Claimant's obstruction which was not reversed by bronchodilators is not occupationally related.** His opinion in respect to this issue is unpersuasive.

Dr. Fino further discusses Claimant's diffusing capacity and lung volumes. He notes Claimant has elevated lung volumes and stale air trapped in his lungs due to his obstructive lung disease. This, he emphasizes, is a typical pattern of obstructive lung disease. Dr. Fino recognizes, however, that pneumoconiosis can cause an obstructive lung disease consistent with Worth, even in the absence of restrictive defect and the absence of contraction of lung tissue.

Dr. Fino explains further that "the **classic** abnormality seen in coal mine dust related pulmonary conditions is **impairment in oxygen transfer**. However, in this case, **the blood gases at rest and with exercise are normal." As I have stated repeatedly, Dr. Fino is, of course, free to characterize as "normal" any clinical test data he reviews**. A trier of fact, however, has an obligation to question such a characterization when there is evidence which suggests it may be inaccurate. Fields v. Island Creek Coal, *supra*; Clark v. Karst-Robbins Coal Co., *supra*.

Claimant's most recent blood gas test, produced a PCO2 of 33 and a PO2 of 65 which satisfies the disability criteria in the regulations. Dr. Fino, of course, may disagree with the regulations, however, **Dr. Fino's interpretation that the blood gases are "normal" is no more binding on a trier of fact than a**

positive x-ray reading which is contradicted by the weight of the evidence. In this instance, not only do the regulations provide that blood gases showing a **PCO2 of 33 and PO2 of 65** are indicative of a totally disabling respiratory impairment, but **Dr. Zaldivar opined that they show "hypoxemia present at rest** which goes along with the degree of obstruction and decrease in diffusing capacity..." Since Compton mandates consideration of this evidence which is, under the case law and the regulations, probative and contrary to Dr. Fino's characterization of the evidence, I believe there is ample basis on this record appropriately to find, contrary to Dr. Fino's characterization, **that Claimant's blood gases are not normal** on the April 10, 1996 blood gas test.

While the Employer expects and insists that trier of fact accept, and must find, that a claimant's blood gas results are "normal" because Dr. Fino said so, the record does not support that conclusion. The record shows, and I believe the Board will find on further review, consistent with Compton, that claimant's blood gas results not only satisfy the disability criteria established by the regulations but have been interpreted by another physician as showing hypoxemia.[4] **Dr. Zaldivar, therefore, did not find claimant's blood gases to be "normal." The employer's "substitution" argument once again is a straw issue since, as the prior decision noted. It is Dr. Zaldivar's interpretation of the objective data that claimant's blood gases show hypoxemia, and it is his interpretation which refutes Dr. Fino's characterization that claimant's blood gases are "normal."**

Should the Board review the merits and the actual findings entered in this matter and find that it is satisfied with explanations Dr. Fino has proffered here, it should then accord his opinion full evidentiary weight in this proceeding for I have no reasons other than those set forth above to question his analysis.

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[4] The Board has held that medical opinions evaluated under Section 718.204(a)(4) must be considered in the context of contrary probative evidence adduced under Sections 718.204 (a)(1)-(4). The Board's decision here seems to contradict these prior holdings. Consequently, if the blood gas data itself can not be considered along with medical interpretations of the data which may be contradictory, further Board guidance will be needed with respect to what other factors the Board will allow a trier of fact to consider in determining when and under what circumstances clinical blood gas data adduced under Section 718.204(a) constitute "contrary probative evidence."

Conclusion

As I noted in my March 25, 1997, and February 2, 1999,decisions, and emphasize here again, I find and conclude that Dr. Rasmussen's opinion is well-reasoned and documented, and I have accorded Dr. Rasmussen's opinion greater weight than the contrary medical opinions offered by pulmonary specialists whose opinions I find less persuasive. For all of the foregoing reasons, I find and conclude that Claimant's coal dust inhalation contributed significantly to his obstructive impairment, and that Claimant, therefore, is totally disabled due to pneumoconiosis arising out of his coal mine employment within the meaning of the regulations.

Alternative Findings

Should the Board find that, despite the foregoing analyses, Dr. Rasmussen's opinion is not well-reasoned and documented, the employer would be correct that benefits must be denied since the evidence would be insufficient to support an award. Further, should be the Board find the Dr. Rasmussen's opinion is entitled to the weight I have accorded it, but further finds that the reasons I have provided are insufficient to diminish the weight accorded to the opinion of Dr. Zaldivar or Dr. Jarboe or Dr. Fino, individually, benefits must be denied because, unlike Drs. Zaldivar, Jarboe, and Fino who are all board-certified in pulmonary diseases, the credentials of Dr. Rasmussen are not in evidence. *See*, Milburn Colliery Co. v. Hicks, 138 F.3d 524 (4th Cir. 1998).

For all of the foregoing reasons, accordingly:

ORDER

IT IS ORDERED that the Employer pay to Claimant all benefits to which he is entitled unto the Act commencing as of August, 1995.

A
Stuart A. Levin
Administrative Law Judge